203 Depression

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Definition

Depression is a subjective experience in which a patient feels sad, unhappy, and often hopeless. The depressed patient experiences little pleasure. Suicidal thoughts are often present.

Technique

Since depression is an almost universal experience, most patients are able to respond directly to questions about it. Although some patients may not understand the term "depression," almost everyone will understand "feeling blue" or "feeling sad." At times, patients with depression may be more aware of associated physical symptoms than of the fact that they are depressed.

The physician should be alert to investigating physical symptoms often associated with the depressive syndrome. These include anorexia, weight loss, menstrual irregularity, difficulty with concentration, insomnia, and easy fatigability. Other complaints may include change in activity level, which may be either agitation or decreased activity. Many depressed patients also have strong feelings of guilt. When these symptoms are present, the physician should always inquire about the presence of depression.

Inquiry into life circumstances will usually elicit conditions that are of concern to the depressed patient. At times, such inquiry will reveal occult depression (i.e., depression that the patient does not recognize). For example, a depressed female patient might mention that her husband has been staying out late at night but deny that she is concerned about this. Although she is denying her concern about her husband, anger toward him is present on an unconscious basis and may be a highly significant cause of her depression. In detecting occult depression, it is particularly useful to have the patient describe activities that bring pleasure. One of the major characteristics of depression is loss of zest for living and a vague feeling that "nothing is worth the effort anymore."

Whenever depression exists, the interviewer should inquire concerning suicidal thoughts. At times, inexperienced interviewers are concerned about asking whether the person has thought of suicide. This concern has little basis. If the patient is deeply depressed, the possibility of suicide will certainly have been considered. There is general agreement among workers in the field of suicidology that asking a patient about suicidal thoughts carries little risk of precipitating a suicide attempt. Omission of inquiry about suicidal thoughts is far more dangerous, since this could result in failure on the part of the physician to take preventive action that could save the patient's life.

Basic Science

The biochemical changes that occur in the brain in depressed patients are of great complexity and are the subject of wide investigation. The metabolism of dopamine, norepinephrine, and serotonin is affected by both tricyclic antidepressants and monoamine oxidase inhibitors. There is, at this point, no definitive evidence regarding which of these monoamines is of critical importance in the development of depression, and it seems likely that all are to some extent involved. The norepinephrine hypothesis of depression postulates that depression occurs because there is an actual or relative decrease in the amount of norepinephrine in central nerve cell synapses. The serotonin hypothesis indicates a similar deficiency of serotonin as being a primary cause for depression. Much is yet to be learned about the biochemical factors in depression. It is clear, however, that although they work by somewhat different cellular mechanisms, both monoamine oxidase inhibitors and tricyclic antidepressants facilitate the action of norepinephrine, dopamine, and serotonin in central synapses. The efficacy of these classes of antidepressants in relieving depression now seems strongly linked to their action upon norepinephrine, dopamine, and serotonin. There is, however, evidence that other neurotransmitters may also be involved in the development of depression.

The subject of suicide has been carefully studied, and most major cities now have a suicide prevention center. Suicide is a major cause of death, with 20,000 to 35,000 suicides recorded annually in the United States. The number of suicide attempts is probably eight to ten times that number.

Since a majority of persons who commit suicide have visited a physician within a few months of their deaths, physicians probably have more opportunities to prevent suicide than any other professional group. Unfortunately, physicians who fail to diagnose serious depression may unwittingly furnish the patient with the means for suicide. Murphy (1975) found that over half the patients in the series of overdose deaths he studied had received recent prescriptions for a lethal amount of hypnotic medication. Since about one-fourth of all suicides are by overdosing with medication, it is apparent that physicians need to be alert for evidence of suicidal potential in their patients. If even the slightest doubt about this possibility exists, the physician should prescribe only small amounts. Many physicians use, as a rule of thumb, the practice of giving no more than five to eight times the hypnotic dose at one time (roughly a one-week supply).

Most suicides are potentially preventable. Characteristically, a person who commits suicide feels ambivalent about what is being done. The act is often carried out impulsively and, if delayed, may not take place at all. It behooves every

physician to make strong efforts to prevent suicide, even to the point of involuntary hospitalization.

Clinical Significance

Depression is a very treatable illness. It can be successfully treated by a variety of measures including cognitive therapy, psychodynamic psychotherapy, behavioral therapy, antidepressant drugs, and electroshock therapy. It is also a potentially fatal condition. It may be a part of many physical illnesses. As mentioned earlier, certain physical findings are characteristically associated with depression. These include loss of appetite, loss of weight (if more than a 6.8-kg [15-lb] weight loss occurs without cause in a 3-month period, the depression is probably quite severe), difficulty with sleeping, and disturbances in menstruation. The patient's inability to sleep is often characterized by awakening in the early morning hours and being unable to return to sleep. Depressed patients also tend to take longer to fall asleep (longer sleep latency). Menstrual disturbances are usually in the direction of sparse, irregular, or absent menses.

The physician is often required to make a judgment concerning suicidal potential. Many factors should be considered in making this judgment, including:

- Expression of intent
- Method chosen
- Impulsivity
- Family history of suicide
- Age and sex
- Living circumstances
- Physical illness
- Religion
- Occupation
- Level of depression
- Psychosis
- Previous history of attempted suicide

In general, it is a wise axiom that the physician should always take seriously any expression of suicidal intention. If the patient mentions plans to commit suicide and is able to describe in meticulous fashion ways of carrying this out, the likelihood of suicide is much higher than if the patient has only vague ideas of "ending it all."

Attempts at suicide in which a method that will produce significant physical disfigurement is chosen are usually considered more serious efforts than those in which there is no such disfigurement potential. Thus, attempts by hanging, use of a gun, or jumping from a building can generally be viewed as more serious than efforts that produce little disfigurement, such as slashing the wrists. The seriousness of suicide attempts by drug overdose can often be judged by the amount of medication taken and the manner in which this was carried out. If a person takes a relatively small dose of medication in circumstances in which early discovery is very likely, there is reason to suspect that the attempt was aimed more at obtaining psychologic support than at actually causing death.

Potential for suicide is higher in patients who are impulsive. Many people carry out the act with some hope that they will be prevented from actually causing their own death. The mood of a person who is considering suicide may change from suicidal to nonsuicidal in a short period of time, even a few hours. Other factors being equal, suicide is less likely if the patient will have to make a considerable effort in order to obtain a drug, a gun, sleeping medication, or other materials for the suicide effort. Consequently, removal of easy access to methods of suicide can have a protective effect.

Many statistical studies demonstrate that a history of suicide by a close relative of the patient significantly increases risk of suicide. Thus, suicidal thoughts in a patient whose mother committed suicide would be regarded as having more serious potential, other factors being the same, than would be the case if there was no family history of suicide.

Suicide is infrequent in children below the age of 12. When it does occur in children below the age of 8, it may be, in a sense, accidental, since the child may not fully understand the finality of the suicidal act. In both adolescents and adults, suicide is a significant cause of death. Suicide is the third leading cause of death among adolescent males. Although women attempt suicide more frequently than men, men actually commit suicide three times as often as women. In adults of both sexes, the incidence of suicide is greater among older age groups, peaking after 45 in men and age 55 in women.

Suicide is considered more likely to occur in a depressed person who has experienced a change in living circumstances that will predispose toward a life of loneliness. In general, people who are living in solitary circumstances are more serious risks for suicide than people who have companions.

Twenty percent of all suicides occur in patients who have a chronic physical illness. Thus the presence of a chronic physical illness heightens the risk of suicide.

Patients who belong to religious groups, such as the Roman Catholic church, that have strong teaching against suicide, have a somewhat lower rate of suicide than the general population.

Occupations that combine high stress with easy accessibility to materials for suicide tend to show a higher rate of suicide. For example, physicians have a higher suicide rate than the general population.

Patients with severe depression are more likely to commit suicide than patients with mild depression. It should, however, be noted that a time of particular danger in depression may occur as a patient is first showing some improvement. Patients can be so depressed that they are unable to pull themselves together sufficiently to commit suicide. Then, as they begin to improve, they become able to organize themselves sufficiently to commit suicide. They may go through a phase in which they are sufficiently organized to carry out the act but still depressed enough to wish to do it, even though their depression is showing improvement. Consequently, patients must be carefully watched during the early stages of improvement from a very severe depression.

Psychotic patients are generally considered to have an increased risk of suicide. This usually relates to their poor reality contact. In some cases, these patients may be having hallucinations that are instructing them to kill themselves.

Physicians are sometimes falsely reassured by the fact that a patient has attempted suicide unsuccessfully several times before. Unless it is very clear that the efforts at suicide were minor and only represented efforts to gain attention, the physician should be more concerned, rather than less concerned, about a patient who has had previous suicide attempts. A high percentage of patients who commit suicide have attempted suicide unsuccessfully at least once before.

Obviously, most patients will not be positive for all the

above items. The clinician must be aware of the presence of these factors and make a judgment of the likelihood of suicide on the basis of the overall picture. In general, the larger the number of these factors present in a single patient, the higher the risk of suicide.

Surprisingly, significant numbers of physicians note the presence of depressive symptoms and then fail to institute treatment because there is a clear explanation for the depression in the patient's life situation. Fawcett (1972) has aptly stated that "the presence of a 'reason' for depression does not constitute a good reason for ignoring its presence."

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